IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
KARL B. KURTZ – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

**CERTIFIED MAIL: 7000 1670 0011 3314 9122**

August 15, 2006

Debbie Freeze, Administrator
Lewiston Rehabilitation & Care Center
3315 Eighth Street
Lewiston, ID 83501

Provider #: 135021

Dear Ms. Freeze:

On **July 27, 2006**, a fire safety survey was conducted at Lewiston Rehabilitation & Care Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be a pattern of deficiencies that constitute no actual harm, but have potential for more than minimal harm and are not an immediate jeopardy, as evidenced by the attached CMS Form 2567L whereby corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Date Certain" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 28, 2006**. Failure to submit an acceptable PoC by **August 28, 2006**, may result in the imposition of civil monetary penalties by **September 18, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **August 31, 2006 (Date Certain)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **August 31, 2006**. A change in the seriousness of the deficiencies on **August 31, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 31, 2006** includes the following:

Denial of payment for new admissions effective **October 27, 2006**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 27, 2007**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact me with your written credible allegation of compliance at the following address:

Bureau of Facility Standards — DHW

3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

If you choose and so indicate, the POC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **July 27, 2006** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR 488.331, you have the opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send a written request which states the specific deficiencies being disputed, and explains why you are disputing those deficiencies. This request must be received by **August 28, 2006**.

All required information should be as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

If your request for informal dispute resolution is received after **August 28, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

MARK P. GRIMES
Supervisor
Facility Fire Safety and Construction

MPG/dmj

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135021 | A. BUILDING 01 - ENTIRE BUILDING<br>B. WING _____ | 07/27/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LEWISTON REHAB & CARE CENTER | 3315 8TH ST<br>LEWISTON, ID 83501 |

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| K 000 | INITIAL COMMENTS<br>The facility is a single story, Type V(111) construction. It has a finished basement and was built in 1965 with a complete renovation in 1998. Smoke detection is in corridors, open spaces, resident rooms, and crawl spaces. The facility is fully sprinklered. Currently the facility is licensed for 96 SNF/NF beds.<br><br>The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on 26-27 July, 2006. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, adopted 11 March, 2003. In accordance with CFR 42, 483.70.<br><br>The Survey was conducted by:<br><br>Chris Laumann, Health Facility Surveyor | K 000 | | |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debbie Reese | TITLE: CD | (X6) DATE: 8-23-06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| K 018 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3<br><br>Roller latches are prohibited by CMS regulations in all health care facilities.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and staff interview during a facility tour it was determined that the facility failed to ensure the proper closure and latching of corridor doors. The defiant practice was identified in 5 of 50 rooms, and affected 10 of 91 residents.<br><br>The finding included:<br><br>1.) During a facility tour of the facility in the morning of 27 July, 2006, between the hours of 9:00 AM and 12 Noon, the doors of rooms 314, 319, 303, 207, and 104 were observed to not properly close and latch. | K 018 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*<br><br>Noted doors were repaired on the day of the survey 7-27-06. Remainder of the facility was inspected and repaired as needed on 7-28-06. Door closure will be monitored by rounds done by the E.D. and maintenance person on a monthly basis | 7-28-06 |

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| K 018 | Continued From page 2<br><br>2.) During a facility tour on the morning of 27 July, 2006, at 10:00 AM, the door to room 308 was observed to be propped open with a trash can.<br><br>Observations were witnessed and noted by survey team as well as the facility maintenance supervisor. | K 018 | | |
| K 027 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, the facility failed to assure that all doors in smoke barriers were self-closing and sealed against the passage of smoke. This deficient practice affected two of five fire compartments.<br><br>Findings include:<br><br>During the facility tour on 27 July, 2006 it was observed by the survey team and maintenance staff at 10:37 AM that the smoke doors | K 027 | | |

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| K 027 | Continued From page 3<br>separating the Rehab wing and B wing did not close fully. When magnetically released, one side of the fire door set was obstructed by the thickness of the newly added carpet preventing it from closing.<br><br>NFPA Standard: NFPA 101, Sect. 8.3.4.1 states that doors in smoke barriers shall completely close the opening leaving only the minimum clearance necessary for proper operation. | K 027 | Doors at rehab were trimmed and tested for proper operation on 7-28-06. Doors are tested on an annual basis by Fisher Systems Doors are tested monthly during required fire drills .<br>This set of doors does **not** separate fire zones, therefore is not a fire door. Please see fire zone map attached. This is further supported as there is no fire barrier in the attic or crawl space . | 7-28-06 |
| K 050 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2<br><br>This STANDARD is not met as evidenced by:<br>Based on interview the facility failed to ensure kitchen staff were famililiar with proper emergency procedures in case of a fire. This effected the 3 kitchen staff who were present at the time of the survey.<br><br>Findings include:<br><br>During walk through of the kitchen area at 11:00 AM on 27 July, 2006, 2 of 3 kitchen staff could not | K 050 | Kitchen staff were inserviced on 7-28-06 by the dietary manager. Continued training will follow on a quarterly basis and will be part of the orientation program for all new dietary employees by the dietary manager. | 7-28-06 |

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| K 050 | Continued From page 4<br>recount proper fire extinguishment procedures when asked by the surveyor. Nor could they identify the location or appearance of the pull handle to activate the fire suppression system. According to federal regulation it is a requirement that, staff are familiar with emergency procedures. NFPA 10.7.1.2<br><br>Observation was witnessed and noted by survey team and facility maintenance supervisor. | K 050 | | |
| K 147 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2<br><br>This STANDARD is not met as evidenced by:<br>Based on observation the facility failed to maintain electrical panels by preventing the exposure to live circuits. The facility had a census of 58 residents all of whom were in danger of being effected in the event a fire had started due to the multiple locations of the violations.<br><br>Findings included:<br><br>1. Three instances of exposed electrical panel circuitry was observed in the facility on 27 July, 2006, one was located in the C hallway electrical panel for the "DW" Freezers in basement at 10:22 AM, another was located in the laundry room elecrical panel which was missing a blank, exposing live circuitry, the final observation was made in the mechanical room at 11:00 AM within | K 147 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*<br><br>Missing electrical circuit breaker blanks were replaced on the day of the survey 7-27-08. At this time all electrical panels throughout the facility were inspected and corrected as needed. This will be checked on a monthly basis by maintenance rounds. | 7-28-06 |

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| K 147 | Continued From page 5<br>the the "attic heater" which was missing approximately ten blanks.<br><br>2. One electrical outlet was observed to be missing an electrical outlet cover plate in B wing within the communications room at 10:50 AM.<br><br>All findings were observed and noted by surveyor and maintenance supervisor. | K 147 | | |

Bureau of Facility Standards

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| C 000 | INITIAL COMMENTS<br><br>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.<br>The facility is a single story, Type V(111) construction. It has a finished basement and was built in 1965 with a complete renovation in 1998. Smoke detection is in corridors, open spaces, resident rooms, and crawl spaces. Currently the facility is licensed for 96 SNF/NF beds.<br><br>The following deficiencies were cited during the annual Fire Life Safety survey conducted on 27 July, 2006. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.<br><br>The Survey was conducted by:<br><br>Chris Laumann, Health Facility Surveyor | C 000 | | |
| C 230 | 02.106,02,b<br><br>b. Existing facilities licensed prior to the effective date of these rules, regulations and minimum standards and in compliance with a previous edition of the Life Safety Code may continue to comply with the edition in force at that time.<br>This Rule is not met as evidenced by:<br>;<br><br>Refer to Federal K tags 018 as it relates to proper | C 230 | | |

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| C 230 | Continued From page 1<br>door closure, 027 as it relates to smoke barriers, 050 as it relates to fire drills, and 0147 as it relates to electrical code requirements. | C 230 | See previous plans of correction.<br>refer to Fed Form keys. | 7-28-06 |